**COUNTY OF LOS ANGELES – DEPARTMENT OF HEALTH SERVICES**
**COMMUNITY PARTNERS – ABILITY-TO-PAY PLAN APPLICATION**
**MY HEALTH LA**

**Name of facility taking this Application: _____**

**Patient: _____ MRUN #: _____ Application ID #: _____ Member ID #: _____**

| FAMILY MEMBERS IN HOME Name | BIRTHDATE Month / Day / Year | Birthplace | EMPLOYED Yes / No | Social Security Number |
|---|---|---|---|---|
| 1 (Adult) | | | | |
| 2 (Adult) | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |

Address: _____ Telephone No.: (____)_____
Number/Street City State Zip Code

Los Angeles County Resident: Yes ☐ or No ☐

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**INCOME EVALUATION:**

Earned Income: $ _____ Family Size: _____
**+** Unearned Income: $ _____
**= Total Monthly Income** (Earned **+** Unearned): $_____
Is patient at or below 138% FPL? ☐ Yes or ☐ No

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It has been preliminarily determined that the Total Adjusted Gross Monthly Income is at or below 138% of the Federal Poverty Level. Therefore, subject the income stated above, all outpatient services received by the patient covered by the application from _____ through _____ are with zero liability.

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I/we understand and agree that this Application is made as part of the County's My Health LA Program which helps low income individuals pay for medical care.

If the patient gets or loses insurance, or if his or her family size or income changes, I/we promise to immediately report that fact to the facility where this Application was completed. I/we further agree that if I/we have any other change in financial circumstances, including but not limited to an increase in the guarantor's income, or the patient, or patient's heirs or personal representative(s) receipt of damages recovered as a result of patient's injury by accident, negligence, or wrongful act, I/we will notify the facility where this Application was completed. This Application may, at the election of the County of Los Angeles, be terminated.

Pursuant to Section 360.5 of the California Code of Civil Procedure, which allows written waivers related to actions for the repayment of County aid, I/we agree that all statutes of limitation upon all debts related to the health care services covered by this Application are hereby waived. This Application shall not in any way diminish or defeat the County's rights which may exist under California Government Code sections 23004.1 and 23004.2, or the Hospital Lien Act, or any other applicable laws, to recover reimbursement from any responsible third-parties, including tortfeasors, the reasonable charges for health care services provided to the patient.

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**I/WE CERTIFY UNDER PENALTY OF PERJURY BY MY/OUR SIGNATURE(S) THAT THE INFORMATION I/WE HAVE PROVIDED AS REQUESTED IN THIS AGREEMENT IS TRUE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE AND BELIEF. I/WE ALSO CERTIFY BY MY/OUR SIGNATURES THAT I/WE HAVE READ AND UNDERSTAND ALL THE FORGOING AND THAT I/WE AGREE TO SIGN THIS STATEMENT WITHOUT ANY RESERVATION WHATSOEVER.**

_____ _____ _____ _____
Patient's Signature Date Interviewer's Signature Date

_____ _____
Responsible Relative Signature Date